TASC

Technical Assistance and Services Center

Flex Program Hour Highlights

Date: *February 14, 2001*
Topic: *Quality Improvement Initiatives in State Flex Programs*
Moderator: *Terry Hill, TASC*
Guests: *John Packham, Robin Keith, John Smith – Nevada*
Kip Smith – Montana
Margaret Farmer – Idaho
Rebecca Brosius – Arkansas

Nevada – John Packham referred to the Quality Assurance and Credentialing Agreement their state created to fulfill the requirement for T195. (The agreement is posted on the TASC web site at www.ruralresource.org/quality.asp.) The Liability Cooperative of Nevada entered into agreement with Beta Healthcare to lead the quality initiative. Within 90 days of granting CAH status, the entities conduct an on-site evaluation of QA policies and procedures. Within 30 days of the evaluation, they send a written report to the CAH outlining the findings of the review and make recommendations for correction of any deficiencies found. The CAH then has 90 days to demonstrate they are in compliance with recommendations and then evaluations are performed annually thereafter to insure continued performance.

The state's first facility went through this program in January 2001. The analysis will produce some "garden variety" info, but it will allow them to track what facilities are doing with quality of care and credentialing. There is no cost to CAHs for this service. The PRO is on the QI task force that helped initiate this program.

Montana – Kip Smith described Montana's Quality Improvement Network created for CAHs to address quality improvement, credentialing, joint peer review, clinical policy and procedure, and annual program review. The program began February 1, 2001 and will run for 2.5 years. The primary concept was to hire a contractor to create a standard set of forms and policies and procedures while customizing them somewhat to each facility. They will also provide training, and monitor the performance and compliance for remainder of the contract.

Participation in the QI network is voluntary, although if CAHs choose not to participate, they still need to find a way to meet federal requirements. The CAHs do not pay for this service other than personnel costs. There are four levels of the program offered: (1) the "base program" meaning the facility receives the materials but implements the program on their own; (2) the facility receives the materials and training for quality assurance/improvement; (3) the facility receives materials and training for medical staff credentialing and peer review; and (4) the complete spectrum of services.

Their challenge is the joint peer review piece. The Montana Supreme Court recently ruled that peer review materials are discoverable in malpractice litigation which means many facilities/providers are uncomfortable doing peer review. The Montana Hospital Association is pursuing legislation to clarify and protect peer review activities and the individuals involved.

The contractor they hired by RFP, Cypress Health Systems, is out of Louisiana but now has an office in Montana. Over the 2.5 years, it will cost $250K.

Idaho – Margaret Farmer stated that the Idaho Hospital Association is the contractor in the state for QI support for the CAHs. They have 16 recently converted CAHs and are at the initial vision and data-gathering stage to see what the needs are at this time. They are currently using the Maryland Quality Indicator Project (MQIP) the IHA requires rural hospitals that have signed a QA agreement with it to participate in the MQIP. Participating hospitals are given individual quarterly reports generated from a set of pre-selected indicators. The reports can be customized (e.g., stratifying findings by similar facilities in the MQIP). The hospital then forwards the indicator scores to the IHA for review and recommendation. When combined with an agreement for an external physician review of 10% of the hospital's peer review cases, the program meets all Flex Program quality provisions.

The IHA is also attempting to identify a person in each hospital to do credentialing, but Margaret noted joint hospital credentialing is a possibility and would probably prove cost effective.

Walt Gregg from the University of Minnesota, Tracking Project, noted that *Findings From the Field, Vol. 2, No. 9* describes both the Idaho and Kansas initiatives. The report may be downloaded at http://www.rupri.org/rhfp-track/results/vol1num9.pdf.

Arkansas – Rebecca Brosius reviewed Arkansas' program, which has been very successful. Utilizing the PRO, Arkansas Foundation for Medical Care, guided by a CAH Quality Initiative Advisory Committee, the state has put together a program utilizing discharge data supplied by the CAHs. This program focuses on 4 DRGs that comprise top utilization diagnosis for the CAHs. There are 11 performance indicators from these 4 DRGs. Monthly, each hospital submits all their discharge data - UB92s - to the PRO. From there, abstracts are run and sent to the facilities for completion. Quarterly "report cards" are provided to the individual hospitals showing their performance benchmarked against the totality of the CAHs as well as the majority of the acute care facilities in the state. This information can be used by the hospital for their internal Quality Assurance initiatives. Additionally, it provided an opportunity for the facilities to see how they processes "work" compared to other hospitals of like size. The CAHs, previously, would not have had any benchmarks against which to compare themselves. The goal of such comparisons is to establish "Centers of Excellence" for treatment of disease entities that are appropriate for treatment in a CAH - should one facility exceed the norm in an area, their processes could be reviewed and eventually replicated in other facilities.

Jerry Coopey, ORHP, asked whether any states have had issues with PRO involvement with CAH quality activities due to conflicts over their role in Medicare quality oversight. Washington, Illinois and Wisconsin did note some concerns from their PRO or HCFA regional offices about potential conflict of interest, but other states indicated they are working closely with their PRO without problem. ORHP will note this in a future meeting with HCFA.

The next Flex Program Hour is scheduled for Wednesday, March 14 at 3:00 p.m. EST. An announcement will be made a week prior to the call.